STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075211	A. Building B. Wing	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Rocky Hill	45 Elm Street Rocky Hill, CT 06067

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 7 residents (Resident #8 and 65) reviewed for notification of change and medication administration, for Resident #8, the facility failed to notify the resident representative when there was a change in the residents condition which required new orders for chest x-rays, new medications, and antibiotic and for Resident #65 the facility failed to ensure the physician was notified when a medication to treat low blood pressure was held without parameters. Additionally, for 1 of 2 residents, (Resident #11) reviewed for abuse, the facility failed to notify the attending physician and the psychiatric provider when the resident pointed his/her finger/hand in the shape of a gun at a nurse aides head and said [NAME]. The findings include: 1. Resident #8 was admitted to the facility in June 2022, with diagnosis that included heart failure, atrial fibrillation, and pulmonary embolism. The annual MDS dated [DATE] identified Resident #8 had moderately impaired cognition and required substantial/maximal assistance with personal hygiene. The care plan dated 4/7/24 identified Resident #8 was at risk for cardiac issues (heart attack, chest pain, stroke) related to cardiovascular disease: atrial fibrillation and congestive heart failure. Interventions included to elevate the head of the bed for comfort level, administer medications as ordered, and watch for signs/symptoms associated with cardio-respiratory issues and report to the physician/APRN. Watch for shortness of breath, cough, increase confusion, chest pain, decreased oxygen saturation levels, and adventitious lung sounds (wheezing, rales). The APRN note dated 4/30/24 indicated she was asked to see Resident #8 for increase coughing and loss of voice. The resident's oxygen saturation was 85% (normal range is 95% - 100%) on room air. And lung sounds were decrease bilaterally with wheezing. New orders for chest x-ray to rule out congestive heart failure, nebulizer treatment three times a day for three days, vital signs every shift for three days, and continue Robitussin three times a day. The APRN note failed to reflect documentation the resident representative had been notified of the new orders for chest x-ray, and new medication. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/24/2024

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 4/30/24 at 12:39 PM identified Resident #8 was alert and forgetful and observed to be coughing with wheezing audible in lung fields. The APRN was notified with new order for chest x-ray. Resident #8 was tested for Covid - 19 which was negative and the oxygen saturation was 94% on room air. The nurse's note failed to reflect documentation that the resident representative was notified of the change in condition, and new order for chest x-ray and new medication. The nurse's note dated 4/30/24 at 10:35 PM identified Resident #8 chest x-ray identified pneumonia, and the results were faxed to the physician. The nurse's note failed to reflect documentation that the resident representative was notified. The nurse's note dated 4/30/24 at 11:06 PM identified on-call physician was notified of Resident #8 chest x-ray result with new orders for Azithromycin (antibiotic) 250mg give 2 tablets (500mg) one time for a day for pneumonia, and Azithromycin 250mg one time a day for 4 days for pneumonia. The nurse's note failed to reflect documentation that the resident representative was notified of chest x-ray result and new antibiotic order. The physician's order dated 5/2/24 directed to extend the nebulizer treatment for 3 more days for congested cough continues. The APRN note dated 5/7/24 identified Resident #8 denied any shortness of breath on oxygen at 2 liters via nasal cannula. Status post antibiotic. Congestive heart failure increase cough persisted. New orders to administer Lasix (diuretic) 60mg for 3 days. Continue with nebulizer three times a day as needed, follow up chest x-ray. The APRN note failed to reflect documentation that the resident representative was notified. The nurse's note dated 5/7/24 at 10:44 AM identified Resident #8 was alert, temperature 98.4, congested cough continues, APRN assessed Resident #8 with new orders for chest x-ray, blood work, Lasix 60mg times 3 days, and continue nebulizer treatment as needed. The nurse's note failed to reflect documentation that the resident representative was notified. The physician's order dated 5/7/24 directed to administer Lasix 60mg daily for 3 days, blood work to be done on Saturday (5/11/24), repeat chest x-ray secondary to coughing, and Albuterol Sulfate Inhalation Solution (2. 5mg/3ml) 0.083%, via nebulizer, three times a day for 3 days, and then as needed for shortness of breath. The nurse's note dated 5/15/24 at 2:18 PM identified Resident #8 was seen by the APRN with new order for Tums in the morning. The nurse's note failed to reflect documentation that the resident representative was notified of new order. The nurse's note dated 4/30/24 through 5/17/24 failed to reflect documentation that the resident representative had been notified of the new orders for chest x-rays, new medication orders, and antibiotic. Interview and review of the clinical record with the DNS on 9/23/24 at 9:00 AM failed to provide documentation that the resident representative had been notified of the new orders for chest x-rays, new medications, and antibiotic. The DNS identified she was not aware of the issue. The DNS indicated it is the responsibility of the nurse who receives the orders to notify the resident or the resident representative of the new orders before the medication is administered. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although attempted, an interview with LPN #5, LPN #7, LPN #8, and RN #10 was not obtained. Review of the facility's change in resident condition/family/physician notification to make resident's physician and representative aware of any significant change in condition. All significant changes in resident's condition will be reported to the physician and representative. An RN assessment will be conducted. The nurse will document in the nurse's notes that the physician and representative or responsible party have been notified of the change in condition. 47457 2. Resident #65 was admitted to the facility on [DATE] with diagnoses that included anemia, nonrheumatic aortic valve stenosis, muscle weakness, and difficulty walking. A physician's order dated 7/21/23 directed to administer 2.5mg Midodrine, 1 tablet by mouth three times daily, for low blood pressure. The annual MDS dated [DATE] identified Resident #65 had a moderately impaired cognition and ambulated independently with a walker. The care plan dated 8/13/24 identified Resident #65 was at risk for cardiac issues (heart attack, chest pain, stroke) related to cardiovascular disease. Interventions included administering medications as ordered, completing labs and x-rays as ordered, and monitoring for chest pain or discomfort (noting the location, severity, quality, and duration of the pain and notify the physician). Medication administration observation on 9/22/24 at 8:05 AM with LPN #1 identified although the 2.5mg Midodrine tablet was scheduled to be administered at that time, it was not. Interview with LPN #1 at that time identified that she was holding the medication because Resident #65's blood pressure was 107/74, and since it was over 100 she would hold it. LPN #1 indicated that there were no parameters included in the physician's order to hold the Midodrine, and no facility policy directing that the Midodrine be held with a systolic pressure greater than 100. LPN #1 identified that because Resident #65's blood pressure was not low, she would hold the Midodrine because it will bring the blood pressure up. Interview with the Medial Director (MD #1) on 9/22/24 at 8:40 AM identified that he was not notified that Resident #65's 9:00 AM dose of Midodrine was not administered, and that he would have expected the medication to be administered with a systolic blood pressure of 107. Interview with the 11:00 PM - 7:00 AM RN Supervisor (RN #2) on 9/22/24 at 9:16 AM identified that he would expect the licensed nurse to clarify with the physician any medication administration parameters, if they were not clear, prior to holding a medication. Review of the September 2024 [DATE]/1/24 through 9/22/24 identified the Midodrine was not administered on the following dates/times: 9/3/24 at 9:00 AM, 9/3/24 at 2:06 PM note text: not available. 9/3/24 at 1:00 PM, 9/3/24 at 2:07 PM note text: not available. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/8/24 at 9:00 AM, 9/8/24 at 8:59 AM note text: 128/70. 9/8/24 at 1:00 PM, 9/8/24 at 12:13 PM note text: 136/86. 9/13/24 at 1:00 PM, 9/13/24 at 12:27 PM note text: 126/78. 9/17/24 at 1:00 PM, 9/17/24 at 12:39 PM note text: 119/75. 9/21/24 at 9:00 AM, 9/21/24 at 10:34 AM note text: 123/87. 9/21/24 at 1:00 PM, 9/21/24 at 2:30 PM note text: 129/63. 9/22/24 at 9:00 AM, blood sugar within normal limits/no coverage. Review of the nurse's notes dated 9/1/24 through 9/22/24 failed to identify documentation that the physician/APRN was notified when Midodrine was not administered. Interview and review of the clinical record with the DNS on 9/24/24 at 12:44 PM failed to identify that the physician/APRN was notified when Resident #65's Midodrine was not administered. The DNS identified that she would expect that if the clinical decision was made to hold a medication that the nursing supervisor or DNS would be notified, as well as the medical provider. The DNS further indicated that if a medication was not given or if a resident refused a medication a progress note should be written and should include documentation that the physician/APRN was notified and any updated orders. The facility's Change in Resident Condition/Family/MD Notification policy directs that all significant changes in a residents' condition will be reported to the physician and family. When there is a significant change in the condition of a resident's physical, mental, or emotional status, or any event of an accident involving the resident: the resident's attending physician shall be notified, the family or responsible party shall be notified, and the nurse will document in the nurse's notes that the physician and family or responsible party have been notified of the change in condition. The facility's Medication Administration policy directs all medications shall be administered safely and accurately in accordance with physician orders, facility protocols, and applicable state and federal regulations. Medications must be administered only with a valid physician's order and orders should be documented clearly and include the resident's name, medication name, dosage, route, frequency, and duration. The policy further directs that residents are monitored for therapeutic effects and potential side effects of medications, adverse reactions or medication errors are immediately reported to the supervising nurse and physician, and incidents of medication errors are documented in the resident's record. 3. Resident #31 had diagnoses that included major depressive disorder, post-traumatic stress syndrome (PTSD), and mild cognitive impairment with memory loss. Resident #31's annual MDS dated [DATE] identified the resident had intact cognition and was independent with all aspect of activities of daily living. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #31 was sent to the hospital on 5/6/24 due to disorientation and a decreased level of consciousness. Resident #31 returned from the hospital on 5/8/24 with a diagnosis of acute encephalopathy of uncertain etiology, possible TIA (Transient Ischemic Attack or mini stroke), essential hypertension, and PTSD/depression. A reportable event form dated 5/10/24 identified Resident #31 attacked Resident #11 with a fork causing an abrasion to the left side of the neck. The attack was witnessed. Both residents were separated immediately and assessed by RN #3. Resident #31 was sent to the hospital for further evaluation. A typed statement signed by SLP #1 dated 5/10/24 identified she went to see Resident #31 at approximately 9:00 AM and the resident was disoriented and saying random things that did not make sense, for example you don't care about me, we are on a yacht how much do you get paid. The SLP identified that a nurse aide entered the room with a drink for the resident and the resident stated, I don't have anyone who cares about me. The SLP left the room and reported the interaction to the nurse. During that conversation with the nurse, there was yelling from Resident #31's room. When SLP arrived at the room, Resident #31 was still on Resident #11's side of the bed and the SLP witnessed Resident #31 pointing his/her finger to the nurse aides head resembling a gesture of a gun. Sharps, razors, small scissors and sharp edge clipping pliers removed from the resident's room by nursing staff. A written statement by LPN #2 dated 5/10/24 identified that a staff member reported that Resident #31 was attacking Resident #11, and Resident #31 was stating that 3 men were trying to hill him/her. A written statement by LPN #11 dated 5/10/24 identified she heard Resident #11 screaming for help, and she walked into the room and Resident #11 stated that Resident #31 stabbed him/her in the neck with a fork. LPN #11 witnessed Resident #31 with a fork in his/her hand. This was reported to the charge nurse. Resident #31 was readmitted to the facility on [DATE] and placed 15-minute checks starting on 5/11/24 at 3:00 PM through 5/13/24 at 2:30 PM without incident. Interview with NA #9 on 9/23/24 at 2:55 PM identified she witnessed the incident on 5/10/24 between Resident #31 and Resident #11. NA #9 indicated she saw Resident #31 approach and wound Resident #11 with a fork in the neck. NA #9 indicated she was able to secure the fork from Resident #31 after contact was made with Resident #11. NA #9 further indicated when she asked for the fork and Resident #31 gave it to her, Resident #31 then took his/her hand and positioned his/her fingers in the shape of a gun and pointed the gun shaped hand toward NA #9 and made a sound [NAME], [NAME]. NA #9 notified the charge nurse, LPN #2, who notified the Nurse Supervisor RN #3. Review of the clinical record, including psychiatric notes, nurses' notes, the care plan, the reportable event form and the hospital discharge summary failed to identify that the physician, the psychiatric provider or the hospital had been made aware that Resident #31 pointed his/her finger toward the nurse aides head in the gesture of a gun and said [NAME].

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on observations, review of facility documentation, facility policy, job descriptions, and interviews the facility failed to ensure the environment was clean, maintained in good condition repair and homelike, and on the Ambrosia unit, the facility failed to secure cable TV wiring resulting in wires hanging from the television sets, obstructing the television screen viewing, and in one room, wiring dangling on the floor. The findings include: 1. Review of the most recent infection control surveillance & safety rounds worksheet dated 7/15/24 (2 1/2 months ago) completed by RN #1 identified documentation that the resident rooms floors, bathrooms, shower and tub rooms floors did not meet a clean environment. The form failed to reflect what units the environmental rounds were performed. Review of the infection control surveillance & safety rounds worksheet dated 7/15/24 completed by the Housekeeping Manager identified documentation that the floors were sticky, did not meet a clean environment. More attention to windowsills and floors are needed. Many resident room floors need stripping and waxing. The form failed to reflect what units the environmental rounds were performed. Observations during the initial tour on 9/22/24 at 6:30 AM through 6:40 AM identified the following: Stains, dirt, debris, and food debris on the floor in the hallway to the lobby, and on all 4 unit hallways. Observations on 9/24/24 at 11:00 AM with the Maintenance Supervisor (from an alternate facility) and the Corporate [NAME] President of Clinical Operations, and observations on 9/24/24 at 1:55 PM through 2:10 PM, at 4:00 PM through 4:20 PM, and at 4:25 PM through 4:35 PM with RN #4 and the Housekeeper Manager identified the following: a. Damaged, chipped, holes, stains, and/or marred bedroom walls on [NAME] unit in rooms 1, 2, 3, 5, 6, 7, 10, 11, 12, 13, 14, 16, and Loung Area. [NAME] unit in rooms 17, 19, 20, 21, 22, 27, 28, 29, and Lounge Area. In room [ROOM NUMBER] and 13, a large amount of missing sheetrock behind bed B. In room [ROOM NUMBER], a blackened adhesive (4) lined up in a strip pattern in between beds and (4) strips under Bed B. b. Damaged, chipped, stains and/or marred walls in the hallways on [NAME] unit and [NAME] unit. c. Damaged, chipped, marred and/or peeling doors in the bedroom on [NAME] unit in rooms 2, 8, 10, and 13. [NAME] unit in rooms 21, and 28. d. Damaged, chipped, marred and/or peeling doors in the bathroom on [NAME] unit in room [ROOM NUMBER]. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Damaged, and/or rusty bedroom radiator on [NAME] unit in rooms 3, and 4. [NAME] unit in rooms 20, and 28. f. Stains, dirt, debris, discoloration, spider web, sticky, and/or wax build up on the floor/crevice in bedroom on [NAME] unit in rooms 1, 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, and Lounge Area. [NAME] unit in rooms 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 29, 31, and Lounge Area. g. Damaged, broken, missing, peeling and/or dirty cove base in the bedroom on [NAME] unit in room [ROOM NUMBER]. h. Damaged, torn, stains, and/or off-track window curtains on [NAME] unit in rooms [ROOM NUMBER]. i. Damaged, torn, stains, and/or off-track privacy curtains on [NAME] unit in rooms 5, and 11. [NAME] unit in rooms 19, and 27. j. Damaged, broken, and/or missing dresser drawer knob in bedroom on [NAME] unit in room [ROOM NUMBER]. [NAME] unit in rooms 20, and 25. k. Damaged, dirt, stain, dust, and/or rusty tray table on [NAME] unit in room [ROOM NUMBER]. l. Damaged, dirt, stain, dust, and/or rusty bed frame on [NAME] unit in room [ROOM NUMBER]. m. Dirt, stain, and/or rusty guard rail on [NAME] unit in room [ROOM NUMBER]. n. Damaged, cracked, and/or missing floor tile in the hallway on [NAME] unit and [NAME] unit. o. Damaged, torn, lifting, and/or peeling non-slip floor strips on [NAME] unit in room [ROOM NUMBER]. p. Damaged, bent, and/or missing window blinds in Lounge Area on [NAME] unit. q. Dirt, debris, and/or spider web on window screen in Lounge Area on [NAME] unit. r. In room [ROOM NUMBER], IV pole with large amount brown buildup around and at the base of the pole. Interview with RN #1 (Infection Preventionist) on 9/24/24 at 1:50 PM identified she was aware of the issues. RN #1 indicated she performs environmental rounds quarterly. RN #1 indicated she has had meetings with the housekeeping department regarding the cleanliness of the resident room floors. Interview with the Administrator on 9/24/24 at 2:20 PM identified she has been with the facility for short time. The Administrator indicated the facility is working on a plan to address the environmental issues. The Administrator indicated going forward there will be a meeting with the maintenance department, the housekeeping department, and RN #1 regarding the expectation of a home like environment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Housekeeper Manager on 9/24/24 at 4:38 PM identified he has been employed by the facility for approximately 2 months. The Housekeeper Manager indicated he was aware of the environmental issues in the resident rooms. The Housekeeper Manager indicated he will be having a meeting with the Administrator, the DNS, RN #4, and housekeeping staffs regarding the environmental cleanliness, and repairs. Interview with RN #4 on 9/24/24 at 4:42 PM identified going forward there will be a meeting with the Administrator, DNS, Maintenance Supervisor, Housekeeping Manager, and RN #1 regarding the repair, and cleanliness of the resident rooms. RN #4 indicated the facility may look for an outside contractor to assist with cleaning the floor in the resident rooms. An interview with 9/24/24 11:00 AM Corporate [NAME] President of Clinical Operations identified the facility was aware of the environmental concerns which staff had been trying to address but realized there was a need for additional resources. The facility had since acquired outside services to address the environmental concerns which was scheduled to begin 9/24/24. Although requested, a policy for maintaining a safe and clean and homelike environment was not provided. Although requested, a facility housekeeping manager job description was not provided. Review of the facility infection control surveillance and safety rounds policy identified to observe facility compliance with infection control policies and procedures. Surveillance rounds are to be conducted on a quarterly basis by the infection control nurse or his/her designee. Review of the facility job description for the maintenance supervisor identified primary purpose of the job is to plan, organizes and directs the maintenance and repairs of the physical plant, equipment and all essential building systems. Ensure the facility is safe and secure while fostering TQM and striving to attain the facility's mission statement. Ensures the compliance with facility policies regarding cleanliness, infection control, safety, security, hazardous communication program and fire and disaster plans. Inspects facility and reports to Administrator any needed repairs with a plan of action and budget. Review of the facility job description for the maintenance technician identified under direct supervision provides quality maintenance services. Assists in the maintenance and repair of the physical plant and grounds, equipment and various building systems. Provides a clean, orderly safe environment for all facility residents and staff. Inspects facility and reports to supervisor any needed repairs. Review of the facility job description for the housekeeping assistant identified the under direct supervision provides quality housekeeping services, and a clean, orderly and safe environment for all facility residents and staff. Reports to supervisor any needed repairs. 2. Observations on the Ambrosia Unit on 9/24/24 at with the Administrator, Housekeeping Manager, and the Maintenance Assistant identified the wiring for the existing cable service provider hanging several inches below the television screens, many obstructing the view of the television screen, and one dangling on the floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator and Housekeeping Manager identified the wiring is part of the existing cable provider and must hang below the television, so the cable unit box is visible for remote control use. The Administrator identified the concern is expected to go away as she was just granted authorization to go with another cable television provider that does not utilize the same equipment, and the extensive wiring will no longer be necessary for remote access. Subsequent to Surveyor inquiry, the wire dangling on the floor was securely attached to the television. The policy for homelike environment was requested however not provided. 37721

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #11) reviewed for abuse, the facility failed to protect Resident #11 from abuse by Resident #31, who stabbed Resident #11 in the neck with a fork. The findings include: a. Resident #11 was readmitted to the facility on [DATE] with diagnoses that included schizophrenia, anxiety disorder, and difficulty walking. The admission MDS dated [DATE] identified Resident #11 had severely impaired cognition, required assistance to stand and transfer, and used a wheelchair or walker for mobility. b. Resident #31 had diagnoses that included major depressive disorder, post-traumatic stress syndrome (PTSD), and mild cognitive impairment with memory loss. Resident #31's annual MDS dated [DATE] identified the resident had intact cognition and was independent with all aspect of activities of daily living. Resident #31 was sent to the hospital on 5/6/24 due to disorientation and a decreased level of consciousness. Resident #31 returned from the hospital on 5/8/24 with a diagnosis of acute encephalopathy of uncertain etiology, possible TIA (Transient Ischemic Attack or mini stroke), essential hypertension, and PTSD/depression. Resident #11's record (nurse's note) dated 5/10/24 at 9:10 AM identified that Resident #11 was attacked by his/her roommate, Resident #31, with a fork and sustained an abrasion to the left side of his/her neck, no acute distress identified, scant amount of blood noted. A reportable event form dated 5/10/24 identified Resident #11 was attacked by his/her roommate (Resident #31) with a fork causing an abrasion to the left side of the neck. The attack was witnessed. Both residents were separated immediately and assessed by RN #3. Resident #11 had an abrasion on his/her neck and Resident #31 was sent to the hospital for further evaluation. Resident #11 was seen by psychiatric services later that day. The police and the resident representatives were notified of the incident. A typed statement signed by SLP #1 dated 5/10/24 identified she went to see Resident #31 at approximately 9:00 AM and the resident was disoriented and saying random things that did not make sense, for example you don't care about me, we are on a yacht how much do you get paid. The SLP identified that a nurse aide entered the room with a drink for the resident and the resident stated, I don't have anyone who cares about me. The SLP left the room and reported the interaction to the nurse. During that conversation with the nurse, there was yelling from Resident #31's room. When SLP arrived at the room, Resident #31 was still on Resident #11's side of the bed and the SLP witnessed Resident #31 pointing his/her finger to the nurse aides head resembling a gesture of a gun. Sharps, razors, small scissors and sharp edge clipping pliers removed from the resident's room by nursing staff. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Rocky Hill	45 Elm Street Rocky Hill, CT 06067

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A written statement by LPN #2 dated 5/10/24 identified that a staff member reported that Resident #31 was attacking Resident #11 and Resident #31 was stating that 3 men were trying to hill him/her. A written statement by LPN #11 dated 5/10/24 identified she heard Resident #11 screaming for help, and she walked into the room and Resident #11 stated that Resident #31 stabbed him/her in the neck with a fork. LPN #11 witnessed Resident #31 with a fork in his/her hand. This was reported to the charge nurse. Resident #31 was readmitted to the facility on [DATE] and placed 15-minute checks starting on 5/11/24 at 3:00 PM through 5/13/24 at 2:30 PM without incident. Interview with NA #9 on 9/23/24 at 2:55 PM identified she witnessed the incident on 5/10/24 between Resident #31 and Resident #11. NA #9 indicated as she was pouring drinks in the hall with the door open, she saw Resident #31 approach and wound Resident #11 with a fork in the neck. NA #9 indicated she was able to secure the fork from Resident #31 after contact was made with Resident #11. NA #9 further indicated when she asked for the fork and Resident #31 gave it to her, Resident #31 then took his/her hand and positioned his/her fingers in the shape of a gun and pointed the gun shaped hand toward NA #9 and made a sound [NAME], [NAME]. NA #9 notified the charge nurse, LPN #2, who notified the Nurse Supervisor RN #3. Interview with the DNS on 9/24/24 at 7:30 AM identified after the incident, she separated the two residents, and both continue to be seen psychiatric services. The Abuse policy directs abuse or mistreatment of any kind toward a resident is strictly prohibited. Anyone witnessing or having knowledge of abuse or mistreatment must notify the DNS or Administrator immediately, an Accident/Incident report will be completed for each resident involved, and the Administrator/DNS/ or Designee shall immediately conduct an investigation, and notification is made to the State Agency within 2 hours of notification of the alleged allegation of abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #11) reviewed for abuse, the facility failed to immediately report to the State Survey Agency, witnessed abuse by Resident #31, who stabbed Resident #11 in the neck with a fork, and failed to report the results of the investigation, in accordance with State law, to the State Survey Agency, within 5 working days. The findings include: a. Resident #11 was readmitted to the facility on [DATE] with diagnoses that included schizophrenia, anxiety disorder, and difficulty walking. The admission MDS dated [DATE] identified Resident #11 had severely impaired cognition, required assistance to stand and transfer, and used a wheelchair or walker for mobility. b. Resident #31 had diagnoses that included major depressive disorder, post-traumatic stress syndrome (PTSD), and mild cognitive impairment with memory loss. Resident #31's annual MDS dated [DATE] identified the resident had intact cognition and was independent with all aspect of activities of daily living. Resident #31 was sent to the hospital on 5/6/24 due to disorientation and a decreased level of consciousness. Resident #31 returned from the hospital on 5/8/24 with a diagnosis of acute encephalopathy of uncertain etiology, possible TIA (Transient Ischemic Attack or mini stroke), essential hypertension, and PTSD/depression. Resident #11's record (nurse's note) dated 5/10/24 at 9:10 AM identified that Resident #11 was attacked by his/her roommate, Resident #31, with a fork and sustained an abrasion to the left side of his/her neck, no acute distress identified, scant amount of blood noted. A reportable event form dated 5/10/24 identified Resident #11 was attacked by his/her roommate (Resident #31) with a fork causing an abrasion to the left side of the neck. The attack was witnessed. Both residents were separated immediately and assessed by RN #3. Resident #11 had an abrasion on his/her neck and Resident #31 was sent to the hospital for further evaluation. Resident #11 was seen by psychiatric services later that day. The police and the resident representatives were notified of the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A typed statement signed by SLP #1 dated 5/10/24 identified she went to see Resident #31 at approximately 9:00 AM and the resident was disoriented and saying random things that did not make sense, for example you don't care about me, we are on a yacht how much do you get paid. The SLP identified that a nurse aide entered the room with a drink for the resident and the resident stated, I don't have anyone who cares about me. The SLP left the room and reported the interaction to the nurse. During that conversation with the nurse, there was yelling from Resident #31's room. When SLP arrived at the room, Resident #31 was still on Resident #11's side of the bed and the SLP witnessed Resident #31 pointing his/her finger to the nurse aides head resembling a gesture of a gun. Sharps, razors, small scissors and sharp edge clipping pliers removed from the resident's room by nursing staff. A written statement by LPN #2 dated 5/10/24 identified that a staff member reported that Resident #31 was attacking Resident #11 and Resident #31 was stating that 3 men were trying to hill him/her. A written statement by LPN #11 dated 5/10/24 identified she heard Resident #11 screaming for help, and she walked into the room and Resident #11 stated that Resident #31 stabbed him/her in the neck with a fork. LPN #11 witnessed Resident #31 with a fork in his/her hand. This was reported to the charge nurse. Resident #31 was readmitted to the facility on [DATE] and placed 15-minute checks starting on 5/11/24 at 3:00 PM through 5/13/24 at 2:30 PM without incident. Interview with NA #9 on 9/23/24 at 2:55 PM identified she witnessed the incident on 5/10/24 between Resident #31 and Resident #11. NA #9 indicated as she was pouring drinks in the hall with the door open, she saw Resident #31 approach and wound Resident #11 with a fork in the neck. NA #9 indicated she was able to secure the fork from Resident #31 after contact was made with Resident #11. NA #9 further indicated when she asked for the fork and Resident #31 gave it to her, Resident #31 then took his/her hand and positioned his/her fingers in the shape of a gun and pointed the gun shaped hand toward NA #9 and made a sound [NAME], [NAME]. NA #9 notified the charge nurse, LPN #2, who notified the Nurse Supervisor RN #3. Interview with the DNS on 9/24/24 at 7:30 AM identified she thought she notified State Agency, and indicated it was an oversite that notification had not been made. The DNS identified after the incident, she separated the two residents, and both continue to be seen psychiatric services. The Abuse policy directs abuse or mistreatment of any kind toward a resident is strictly prohibited. Anyone witnessing or having knowledge of abuse or mistreatment must notify the DNS or Administrator immediately, an Accident/Incident report will be completed for each resident involved, and the Administrator/DNS/ or Designee shall immediately conduct an investigation, and notification is made to the State Agency within 2 hours of notification of the alleged allegation of abuse.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 37293 Based on review of the clinical record, facility documentation, and interviews for 1 of 5 residents (Resident #2) reviewed for Pre-Admission Screening and Record Review (PASARR), the facility failed to complete a rescreen PASARR following a new serious mental disorder diagnoses that was identified on 1/13/22. The findings included: Resident #2 was admitted to the facility in August 2019 with diagnoses that included delusional disorder, paranoid personality, and anxiety disorder. A PASARR level 1 screening dated 8/15/19 identified that Resident #2 had a diagnoses of anxiety disorder and noted the utilization of Seroquel (antipsychotic medication) for treatment. Based on information that was received, a Level II evaluation is not required at this time and this Level I was approved with a Level I negative outcome. Should there be an exacerbation related to the mental illness, a status change should be submitted to Ascend for further evaluation. A Connecticut Long Term Care (LTC) Level of Care Determination Form with a review date of 11/11/19 identified admitting diagnoses hypertensive urgency. Resident #2 required monitoring of changes in lab values, vitals, and fluctuations in medical presentation. The assessment further noted that the level of care outcome for Resident #2 was determined to be long term approval with an effective date of 11/13/19. A review of the clinical record identified that a diagnoses for schizophrenia was added to the resident's profile on 1/13/22. Further review of the clinical record failed to identify that a Level II PASARR screening had been completed following the introduction of a new psychiatric diagnoses on 1/13/22. A review of the clinical record failed to reflect that Resident #2 was seen by psychiatry in the month of January 2022 or February 2022 following the new psychiatric diagnoses of schizophrenia on 1/13/22. The psychiatric APRN note dated 9/22/22 identified Resident #2 has a psychiatric diagnosis of schizophrenia. Mood and medication evaluation. Staff report Resident #2 with no negative behaviors. Resident #2 well managed on current medication regimen. The care plan dated 8/16/24 identified Resident #2 had a diagnoses of schizophrenia disorder and risk for changes in mood state and behaviors. Interventions included follow up psychiatrist as needed. Administer medication as ordered. Watch for and report new onset or increase in symptoms: Delusions, hallucinations, bizarre or unusual behavior, and depression. Interview with the DNS on 9/24/24 at 9:30 AM identified she was not aware of the issue. The DNS indicated that the social worker at that time was responsible for the PASARR's. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of the clinical record with Social Worker (SW) #1 on 9/24/24 at 4:11 PM identified she has been employed by the facility for approximately 2 years. SW #1 indicated she was not aware of the issue. SW #1 indicated at the time that Resident #2 had a change in mental disorder diagnoses on 1/13/22 a PASARR rescreen referral should have been completed. SW #1 indicated she has put a system in place in the facility for residents with new diagnoses that might trigger a referral to the state agency for Level II PASARR assessment. SW #1 indicated she will address the issue and refer Resident #2 for a PASARR rescreen. A review of the facility preadmission screening and resident review (PASARR) policy identified it is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for short/long term care. All applicants to a Medicaid-certified nursing facility are evaluated for mental illness and/or intellectual disabilities to ensure they are placed in the appropriate setting and receive the services they need in the nursing home setting. Ascend is responsible for the following services under contract with Connecticut Department of Social Services: Conducting Level II evaluations for persons known or suspected of having serious mental illness that are residing in or applying to a Medicaid Certified nursing facility.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46040 Based on review of the clinical record, facility documentation, facility policy, and interviews for 2 of 7 residents (Resident #19 and 26) reviewed for falls, the facility failed to ensure that an RN assessment was completed after an unwitnessed fall, and failed ensure post-accident and incident (A&I) assessments and neurological assessments were initiated and completed per facility policy following unwitnessed falls and for 1 of 4 residents (Resident #65) reviewed for medication administration, the facility failed to ensure a medication was administered per the physician's order. The findings include: 1. Resident #19 was admitted to the facility on [DATE] with diagnoses that included dementia, weakness, and cardiomegaly. The quarterly MDS dated [DATE] identified Resident #19 had severely impaired cognition, was frequently incontinent of bowel, occasionally incontinent of bladder and required partial assistance from staff with dressing and maximal assistance with toileting and bathing. The MDS also identified Resident #19 had no history of falls in the last 3 months. The care plan dated 4/25/24 identified Resident #19 was at risk for falls due to multiple risk factors that included unsteady gait. Interventions included to provide a well-lit clutter free environment. A reportable event form dated 6/14/24 at 8:25 AM identified Resident #19 had an unwitnessed fall. Review of the clinical record failed to reflect that Resident #19 was assessed by a registered nurse after the unwitnessed fall on 6/14/24. Review of the post A&I assessment flowsheet dated 6/14/24 identified one entry completed for the 7:00 AM - 3:00 PM shift which identified Resident #19 had no skin bruising, issues with range of motion, or pain. Review of the clinical record including the reportable event form failed to reflect neurological assessments or any additional post A&I assessments had been done after Resident #19 fell on [DATE]. 2. Resident #26 was admitted to the facility on [DATE] with diagnoses that included history of falling, muscle weakness, and anemia. A fall risk assessment dated [DATE], completed 8 weeks after admission, identified Resident #26 was at risk for falling. The care plan dated 10/13/23 identified Resident #26 was at risk for falls. Interventions included keeping the call bell within reach when in bed or bedside chair and use of proper footwear and nonskid socks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly MDS dated [DATE] identified Resident #26 had moderately impaired cognition, was always incontinent of bowel and bladder, and was dependent on staff for assistance with toileting and dressing, substantial staff assistance with transfers, and required use of a walker. Review of the clinical record identified Resident #26 had 2 unwitnessed falls within 24 hours on 12/21/23 and 12/22/23. A nurse's note dated 12/21/23 at 9:19 AM identified Resident #26 had an unwitnessed fall and was found on the floor of his/her room on 12/21/23 at 6:30 AM after falling out of bed. A nurses note dated 12/22/23 at 8:03 AM identified Resident #26 was found on the floor of his/her room at 12:00 AM after attempting to get out of bed to get something to eat. a. A reportable event form dated 12/21/23 identified Resident #26 had an unwitnessed fall at 12:00 AM on 12/21/23. Review of the report and investigation statements include documentation and statements related to 2 separate falls: 12/21/23 at 6:30 AM and 12/22/23 at 12:00 AM. Review of the clinical record identified incomplete neurological assessments and post A&I assessment monitoring following Resident #46's falls on 12/21/23 and 12/22/23. Review of the neurological check and post A&I assessment flowsheets, included with the 12/21/23 reportable event form identified an undated neurological check flowsheet with an initial check done at 6:35 AM with checks every 15 minutes x4. The undated neurological check flowsheet then identified a check done at 3:00 PM, 3 - 4 AM, and times identified as 11-7 and 3-11 with no dates identified. The post A&I assessment flowsheet identified an incident date and time of 12/21/23 at 6:30 AM. Review of the assessment failed to identify any neurological assessments and post A&I assessment monitoring related to the 12/22/23 fall. b. Review of the clinical record and reportable event form dated 3/25/24 at 3:30 PM identified Resident #26 had an unwitnessed fall. The clinical record failed to identify any neurological checks were conducted or completed following this fall. c. Review of the clinical record and reportable event form dated 3/25/24 at 3:30 PM identified Resident #26 had an unwitnessed fall. The clinical record failed to identify any neurological or post A&I assessments were conducted or completed following this fall. d. Review of the clinical record and facility A&I report identified Resident #26 had an unwitnessed fall on 4/9/24 at 4:01 PM. The clinical record failed to identify any neurological or post A&I assessments were conducted or completed following this fall. e. Review of the clinical record and reportable event form dated 6/18/24 at 9:40 PM identified Resident #26 had an unwitnessed fall. The clinical record failed to identify any neurological assessments were conducted or completed after the 7:00 AM - 3:00 PM shift on 6/20/24 (42 hours after the fall). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with MD #1 on 9/24/24 at 9:15 AM identified that he would not expect the facility to initiate neurological monitoring if a resident had been sent to the hospital for evaluation following an unwitnessed fall, as he felt the hospital would provide discharge orders to the facility related to any neurological monitoring. MD #1 identified that if a resident was not sent to the hospital for evaluation, and the resident had an unwitnessed fall with possible head strike, then he would expect the facility to initiate neurological monitoring per policy. Interview with the DNS on 9/24/24 at 9:30 AM identified that the facility policy regarding unwitnessed falls included neurological monitoring and post A&I assessments. The DNS identified that Resident #19 and Resident #26 should have had neurological monitoring initiated after each unwitnessed fall, and in addition, post A&I assessments should have been completed every shift. The DNS also identified that nurses complete either a SBAR note or a narrative note that should include a physical assessment of the resident following any fall and would check into the assessment following Resident #19's fall on 6/14/24. The status post A&I assessment form identified that the assessment form should be completed every shift for 72 hours following an accident or incident, and the physician should be notified if there were any new or worsening symptoms. Although requested, the facility failed to provide a policy related to post accident and incident assessments. The facility policy on change of condition directed that in the event of an accident involving a resident, a RN assessment would be conducted. The facility policy on falls directed that after a resident fall, a RN assessment would occur. The policy also directed that post A&I assessments and neurological checks would be completed for any resident that experienced an unwitnessed fall and was unable to accurately verbalize a head strike due to cognitive status. The facility policy on neurological checks directed that neurological checks were a nursing measure used to assess a resident's neurological status following a head injury or any other situation that might alter the resident neurological status. The policy further directed that the neurological flow sheet would be instituted by the nurse and would be completed every 15 minutes for the first hour, every hour for 4 hours, every 4 hours for the next 24 hours, and every shift for 48 hours after that. The policy directed that the flowsheet documentation should include the date and time of the assessment, the level of consciousness, the pupillary response, the strength/sensation of the extremities, and vital signs. The facility policy on accident and incident reporting directed that post A&I assessments would be completed by licensed nursing staff for 72 hours after an accident/incident. 47457 3. Resident #65 was admitted to the facility on [DATE] with diagnoses that included anemia, nonrheumatic aortic valve stenosis, muscle weakness, and difficulty walking. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated 7/21/23 directed to administer 2.5mg Midodrine, 1 tablet by mouth three times daily, for low blood pressure. The annual MDS dated [DATE] identified Resident #65 had a moderately impaired cognition and ambulated independently with a walker. The care plan dated 8/13/24 identified Resident #65 was at risk for cardiac issues (heart attack, chest pain, stroke) related to cardiovascular disease. Interventions included administering medications as ordered, completing labs and x-rays as ordered, and monitoring for chest pain or discomfort (noting the location, severity, quality, and duration of the pain and notify the physician). Medication administration observation on 9/22/24 at 8:05 AM with LPN #1 identified although the 2.5mg Midodrine tablet was scheduled to be administered at that time, it was not. Interview with LPN #1 at that time identified that she was holding the medication because Resident #65's blood pressure was 107/74, and since it was over 100 she would hold it. LPN #1 indicated that there were no parameters included in the physician's order to hold the Midodrine, and no facility policy directing that the Midodrine be held with a systolic pressure greater than 100. LPN #1 identified that because Resident #65's blood pressure was not low, she would hold the Midodrine because it will bring the blood pressure up. Interview with the Medial Director (MD #1) on 9/22/24 at 8:40 AM identified that he would have expected the morning dose of Midodrine to be administered with a blood pressure reading of 107/74. MD #1 further identified that while there were no parameters in the order to hold the medication, as the parameters can vary and he would expect it to be treated individually, generally he would expect Midodrine to be held with a systolic blood pressure reading greater than 140. Interview with LPN #1 and RN #2 on 9/22/24 at 8:45 AM identified that LPN #1 did not administer Resident #65's morning dose of Midodrine due to the blood pressure reading of 107/74. RN #2 identified that there were no parameters in the Midodrine order directing when to hold the medication and he was unaware of a facility policy for Midodrine administration. RN #2 indicated that he would follow up with expectations for holding Midodrine when the order that does not include parameters. Interview with the 11:00 PM - 7:00 AM RN Supervisor (RN #2) on 9/22/24 at 9:16 AM identified that he would expect the licensed nurse to clarify with the physician any medication administration parameters, if they were not clear, prior to holding a medication. Further, RN #2 indicated he spoke with the physician regarding Resident #65's Midodrine order and moving forward parameters to hold the medication would be in place. A physician's order dated 9/23/24 directed to administer 2.5mg Midodrine, 1 tablet by mouth three times daily, for low blood pressure, hold is systolic blood pressure (SBP) is greater than 140, or if diastolic blood pressure (DBP) is more than 90. Review of the September 2024 [DATE]/1/24 through 9/22/24 identified the Midodrine was not administered on the following dates/times: 9/3/24 at 9:00 AM, 9/3/24 at 2:06 PM note text: not available. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/3/24 at 1:00 PM, 9/3/24 at 2:07 PM note text: not available. 9/8/24 at 9:00 AM, 9/8/24 at 8:59 AM note text: 128/70. 9/8/24 at 1:00 PM, 9/8/24 at 12:13 PM note text: 136/86. 9/13/24 at 1:00 PM, 9/13/24 at 12:27 PM note text: 126/78. 9/17/24 at 1:00 PM, 9/17/24 at 12:39 PM note text: 119/75. 9/21/24 at 9:00 AM, 9/21/24 at 10:34 AM note text: 123/87. 9/21/24 at 1:00 PM, 9/21/24 at 2:30 PM note text: 129/63. 9/22/24 at 9:00 AM, blood sugar within normal limits/no coverage. Review of the nurse's notes dated 9/1/24 through 9/22/24 failed to identify documentation that the physician/APRN was notified when Midodrine was not administered. Interview and review of the clinical record with the DNS on 9/24/24 at 12:44 PM identified she was not aware that Resident #65's Midodrine was being held without parameters or medical provider notification/clarification. The DNS indicated that she would expect the nursing supervisor and/or DNS to also be notified when the clinical decision to hold a medication was made. The DNS further indicated that she would expect the nurse to administer all medications per the physician's order and to clarify parameters with the physician/APRN, when necessary. The facility's Medication Administration policy directs all medications shall be administered safely and accurately in accordance with physician orders, facility protocols, and applicable state and federal regulations. Medications must be administered only with a valid physician's order and orders should be documented clearly and include the resident's name, medication name, dosage, route, frequency, and duration. The policy further directs that residents are monitored for therapeutic effects and potential side effects of medications, adverse reactions or medication errors are immediately reported to the supervising nurse and physician, and incidents of medication errors are documented in the resident's record.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Rocky Hill	45 Elm Street Rocky Hill, CT 06067

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43032 46040 Based on observations, review of the clinical record, facility documentation, facility policy, and interview ,the facility failed to ensure that one of 2 emergency exit points on a resident unit was free of equipment and clutter to allow access to the exit doors; and for 1 of 7 residents (Resident #26) reviewed for falls, the facility failed to ensure that fall risk assessments were completed for a resident with a history of multiple falls with injury. The findings include: 1. During an initial tour and observation of the facility on 9/22/24 at 8:27 AM on the Ambrosia unit identified 2 emergency fire exit points on the unit; one located at the north most end of the unit, and a second located to the west side of the unit at the end of a corridor/hallway area. While the exit doors located at the north end of the unit were clear and accessible, the emergency exit doors located at the end of the west side corridor were not accessible. Observation identified that along the left side of the corridor, 3 soiled linen/trash carts positioned lengthwise beginning at the corridor entrance on the unit, and a stand assist (Stedy) device located that the end of the corridor in front of the left exit door. The stand assist device was also positioned directly in front of the fire extinguisher storage door embedded in the left wall. Observation also identified along the right side of the wall were 5 wheelchairs beginning the corridor entrance, and 2 Hoyer lifts located that the end of the corridor directly in front of the right exit door. This observation identified a space of approximately 18 - 24 inches between the right and left sides of the corridor from the entrance of the corridor to the emergency exit doors. Observation and interviews of the west side emergency exit corridor on the Ambrosia unit with the DNS and Administrator on 9/22/24 at 8:30 AM identified that the corridor should have provided full access to the emergency exit and should not have equipment placed anywhere that would block full access to the doors or fire extinguisher. The DNS and Administrator identified that any residents who required wheelchair assistance or transport out of the facility in their beds due to immobility would be unable to exit from the emergency exit due to the amount of equipment in the way. The DNS and Administrator identified that they would address the issue immediately. Subsequent to surveyor inquiry, observation on 9/22/24 at 8:41 AM identified that the emergency exit doors were accessible. Observation identified 2 Hoyer lifts, a stand assist device, and an electronic weight scale located on the right side of the corridor, approximately 24 inches from the emergency with the equipment positioned to the right side of the corridor against the wall. During this observation, the fire extinguisher and emergency exit doors were fully accessible. Observation on 9/23/24 at 8:40 AM identified that the Ambrosia west side emergency exit doors were partially blocked. During this observation, 2 soiled linen/trash carts positioned lengthwise at the midpoint between the corridor entrance and the emergency exit door on the left side. The soiled linen/trash cart located in front of the left exit also was positioned directly in front of the fire extinguisher storage door. Observation of the right side of the corridor identified 2 large wheelchairs positioned at the end of the corridor directly in front of the right emergency exit door, and an electronic weight scale located at the corridor entrance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 9/24/24 at 9:25 AM identified access to the Ambrosia west side corridor was partially blocked. During this observation, a Hoyer lift was observed near the entrance to the corridor along the left side wall. A stand assist device (Stedy), a large wheelchair, a 2nd Hoyer lift, and a 2nd wheelchair were observed along the right side of the corridor, in front of the right emergency exit door. This observation identified approximately 18 inches of space between the Hoyer lift on the left and the stand assist device on the right side of the corridor. Interview with the DNS on 9/24/24 at 9:30 AM identified that she would need to provide additional education with the staff regarding the emergency exits. The DNS identified that fire safety was reviewed with the staff annually and that the emergency exits should not be blocked. The facility policy on fire safety directed that all passageways, corridors, and fire door exits should be clear of all obstructions. 2. Resident #26 was admitted to the facility on [DATE] with diagnoses that included history of falling, muscle weakness, and anemia. A fall risk assessment dated [DATE], completed 8 weeks after admission, identified Resident #26 was at risk for falling. The care plan dated 10/13/23 identified Resident #26 was at risk for falls. Interventions included keeping the call bell within reach when in bed or bedside chair and use of proper footwear and nonskid socks. The quarterly MDS dated [DATE] identified Resident #26 had moderately impaired cognition, was always incontinent of bowel and bladder, and was dependent on staff for assistance with toileting and dressing, substantial staff assistance with transfers, and required use of a walker. Review of the clinical record identified Resident #26 had unwitnessed falls on 12/21/23 and 12/22/23. Review of the clinical record identified Resident #26 had a fall risk assessment completed on 2/25/24 following an unwitnessed fall which identified that Resident #26 was at risk for falls. Review of the clinical record identified that Resident #26 had falls on the following dates: 2/27, 3/25, 4/9, 4/29, 6/18 and 8/2/24. Review of the clinical record identified Resident #26 had a fall risk assessment completed on 8/2/24 which identified that Resident #26 was at risk for falls. Review of the clinical record identified Resident #26 had an unwitnessed fall with injury on 8/6/24. A reportable event form dated 8/6/24 identified Resident #26 required transfer to the hospital on 8/6/24 and returned on 8/7/24 with a diagnosis of a nasal fracture. Review of the clinical record identified Resident #26 had an unwitnessed fall with injury on 8/31/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A reportable event for dated 8/31/24 identified Resident #26 required transfer to the hospital and returned on 9/1/24 with a diagnosis of a left clavicle fracture. Review of the clinical record failed to identify any additional fall risk assessments for Resident #26. Interview with the DNS on 9/24/24 at 9:30 AM identified that Resident #26 should have had fall risk assessments completed on admission and at least quarterly, but that she was unsure about any other instance when they should be completed. The DNS identified that Resident #26 had several falls at the facility and several interventions had been put into place, including fall mats around Resident #26's bed. The facility policy on falls directed that the purpose of policy included identifying residents' at risk for falling and minimizing injuries when a fall occurs. The policy directed that resident should be assessed for risk of falling upon admission, quarterly, annually, and after a significant change in condition. The policy further directed those residents who experienced a fall would be also be evaluated following each occurrence using the interdisciplinary fall assessment tool to identify the potential causes of the fall, and that an individualized care plan would be developed and updated as needed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on review of the clinical record, facility documentation and interviews for 3 of 5 residents (Resident #11, 18 and 39) reviewed for respiratory care, the facility failed ensure respiratory equipment was maintained and stored in a clean and sanitary manner and respiratory equipment was changed according to physician orders. The findings include: 1. Resident #11 had diagnoses that included chronic obstructive pulmonary disease (COPD), heart failure and history of hypoxemia (low oxygen level). The quarterly MDS dated [DATE] identified Resident #11 was cognitively intact, required limited one person assist with bed mobility and transfers, independent with eating. The care plan dated 7/3/24 identified Resident #11 was at risk for respiratory distress related to COPD. Interventions included to notify the physician for congestion wheeze, shortness of breath and provide oxygen/medications as ordered. Physician orders dated 9/1/24 directed to administer oxygen at 3 liters per minute for oxygen saturation less than 90% and oxygen tubing changes weekly every Sunday night shift (11:00 PM - 7:00 AM). Observation on 9/22/24 at 7:26 AM with LPN # 3 identified Resident #11 was lying in bed with oxygen being delivered at 3 liters/minute by nasal cannula. The tape adhered to the oxygen tubing was dated 9/2/24, 20 days prior. Interview with LPN #3 identified the oxygen tubing should have been changed sometime within the current week. A second observation on 9/23/24 at 5:38 AM identified the oxygen tubing remained dated 9/2/24. Interview with LPN #4 on 9/23/24 at 6:31AM identified he was the assigned charge nurse for the 11:00 PM - 7:00 AM. LPN #4 identified it was the night shift licensed staff's responsibility to change the oxygen tubing weekly on Sundays. LPN # 4 identified Resident #11's oxygen tubing should be changed and dated weekly. Interview with the DNS on 9/23/24 at 6:43 AM identified she would expect the oxygen tubing be changed in accordance with physician orders. Although requested, a policy detailing the care and management of oxygen equipment was not provided. 2. Resident #18 had diagnoses that included COPD, history of Covid 19 infection and left sided hemiplegia/hemiparesis (weakness and paralysis) secondary to a history of stroke. The quarterly MDS dated [DATE] identified Resident #18 was cognitively intact and required substantial/dependent two person assist with activities of daily living (ADL) skill, independence with eating. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The care plan dated 7/18/24 identified Resident #18 was at risk for respiratory distress related to COPD. Interventions included to notify the physician for congestion wheeze, shortness of breath and provide medications as ordered. The physician orders dated 9/1/24 directed to administer albuterol sulfate nebulization solution, (1) unit every (4) hours as needed for wheezing/shortness of breath. Review of the September 2024 MAR identified the Albuterol nebulizer treatment was last administered on 9/21/24 at 1:13 PM. Observation on 9/22/24 at 10:33 AM with LPN #3 identified the nebulizer mask was placed on top of the bedside table with no label or cover. Interview with LPN #3 on 9/22/24 at 10:33 AM identified the nebulizer mask should have been stored in a plastic bag when not in use. Interview with the DNS on 9/23/24 at 6:43 AM identified any equipment not in use should be labeled with a name, dated and stored in the bag. Although requested, a policy detailing the care and management of oxygen equipment was not provided. 3. Resident #39 had diagnoses that included COPD and recent history of pneumonia. The nursing admission assessment dated [DATE] identified Resident #39 had consistent memory recall to place/person and required one person assist with function ADL care. Physician orders dated 9/7/24 directed to administer Albuterol Sulfate nebulization solution (2.5mg/3ml) 3mls via nebulizer every (8) hours as needed for shortness of breath. The care plan dated 9/8/24 identified Resident #39 was at risk for respiratory distress related to a diagnosis of COPD. Interventions directed to report any shortness of breath that occurs and provide medications as ordered. Observation with LPN #3 on 9/22/24 at 7:24 AM identified a bilevel positive airway pressure (BiPAP) mask on the floor behind the bed uncovered and a nebulizer mask on the bedside table on top of nebulizing machine, uncovered and without a label. Interview with LPN #4 on 09/22/24 at 8:18 AM identified he was the assigned charge nurse for the 11:00 PM - 7:00 AM shift. LPN #4 identified Resident #39 refuses to use his/her nebulizer mask and BiPAP. However, both should have been stored in a bag when not in use. Interview with the DNS on 9/23/24 at 6:43 AM identified any equipment not in use should be labeled with a name, dated and stored in the bag. A physician's order for the use the BiPAP machine was not located. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although requested, a policy detailing the care and management of oxygen equipment was not provided.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on observation, review of the clinical record, facility documentation, facility policies, and interviews for the only sampled resident (Resident #14) reviewed for a specialized medical treatment, the facility failed to maintain an accurate daily fluid intake record for a resident on a fluid restriction. The findings include: Resident #14 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease, dependence on a specialized medical treatment, diastolic (congestive) heart failure, and chronic constrictive pericarditis. Physician's orders for September 2024 (original date 10/19/21) directed a fluid restriction: 1000ml in 24 hours. The annual MDS dated [DATE] identified Resident #14 had intact cognition, was on a therapeutic diet, and had received dialysis within the last 14 days. The care plan dated 9/19/24 identified Resident #14 was at risk for impaired nutrition, inadequate energy/fluid intakes, fluid overload, and weight fluctuations in the setting of chronic illness requiring a therapeutic diet order, fluid restriction, and specialized medical treatment three times per week; Resident #14 chooses to be non-compliant with diet and fluid restrictions some days despite education and was at risk for cardiac issues related to hypertension, atrial-fibrillation, hyperlipidemia, cardiomyopathy, ischemic heart disease, and chronic pericarditis. Interventions included monitoring intake and output per the facility's policy and maintaining a fluid restriction as ordered by the specialized medical treatment center. The care plan identified Resident #14 was at risk for cardiac/respiratory distress and related complications due to congestive heart failure. Interventions included monitoring intake and output as ordered and maintaining a fluid restriction per the physician's order. Interventions included maintaining a fluid restriction per the physician's order, encouraging compliance, and monitoring for signs and symptoms of fluid overload and report such signs and symptoms to the physician/APRN. The annual nutritional assessment dated [DATE] at 3:51 PM identified that Resident #14 was on a 1000cc daily fluid restriction and based on a 3 day look back, he/she averaged a daily fluid intake of 980ml per day. The nutritional assessment further identified the dietitian's recommendations and goals were as follows: diet as ordered, carbohydrate controlled, renal, regular texture, thin liquids - 1000ml fluid restriction and Resident #14 will have no significant unplanned weight changes and will maintain compliance with dietary guidelines and restrictions. Review of the Intake and Output log (located in a binder at the nurse's station) dated 9/1/24 through 9/24/24 failed to identify accurate daily intake totals, due to missing documentation on the following days/shifts: 9/2/24 7:00 AM - 3:00 PM 9/4/24 11:00 PM - 7:00 AM (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/6/24 11:00 PM - 7:00 AM 9/6/24 7:00 AM - 3:00 PM 9/8/24 7:00 AM - 3:00 PM 9/12/24 7:00 AM - 3:00 PM 9/13/24 7:00 AM - 3:00 PM 9/19/24 11:00 PM - 7:00 AM 9/19/24 7:00 AM - 3:00 PM 9/20/24 7:00 AM - 3:00 PM 9/21/24 7:00 AM - 3:00 PM 9/22/24 7:00 AM - 3:00 PM The September 2024 MAR, TAR and nurse's notes dated 9/1/24 through 9/23/24 failed to identify Resident #14's shift or daily fluid intake totals. Interview with NA #1 on 9/23/24 at 11:58 AM identified that it is the responsibility of the nurse aide caring for the resident to record the shift intake totals into the Intake and Output binder. NA #1 further identified that she had worked on 2 of the 12 shifts that had missing intake documentation, but Resident #14 was not on her assignment during those shifts. Interview with the 7:00 AM- 3:00 PM RN Supervisor (RN #3) on 9/23/24 at 12:12 PM identified that the nurse aide can record intake totals into the binder or give it to the charge nurse, who ultimately is responsible for documenting the intake totals, each shift. RN #3 indicated that her expectation is that charge nurses maintain and monitor fluid restrictions, per the physician's order to ensure the resident is not taking in too much fluid. Interview with the DNS on 9/23/24 at 12:18 PM identified that she would expect intake totals to be documented in the Intake and Output log and tallied at the end of each shift. The DNS indicated that nurse aides can document the intake values in the log, but it is the responsibility of the charge nurse to ensure shift totals are documented. The DNS identified that even on days that Resident #14 received dialysis treatments, outside of the facility, accurate intake totals were still expected because Resident #14 could report to the nursing staff what he/she consumed. Interview with LPN #5 on 9/24/24 at 2:37 PM identified that she had provided care to Resident #14 within the last month. LPN #5 indicated that it was the responsibility of the charge nurse to document the resident's shift intake totals into the binder; the nurse aide could also enter the intake totals into the binder, but it is up to the nurse to ensure documentation. LPN #5 further indicated that she couldn't recall any shifts where she missed documenting Resident #14's intake totals, but if she did it wasn't intentional, as she always tries to ensure intake totals were documented, when indicated. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Hemodialysis policy directs the facility is responsible to provide pre and post dialysis care to the resident while at the facility, including maintaining fluid restrictions as ordered, monitoring intake and output, and notifying the physician and dialysis if the resident was not compliant with fluid restrictions. The facility's Intake and Output (I&O) policy directs that all nursing personnel are responsible for recording on the I&O record, the nurse is responsible for completing the subtotal I&O at the end of each shift, I&O will be totaled for all three shifts at the end of each 24 hour period by the nurse, I&O are instituted on admission and then quarterly for all residents and if there is a physician's order or a nursing measure on any resident with: antibiotic therapy, change in condition which may alter hydration status, fluid restriction, IV therapy, fever, and tube feedings. The policy further directs that if a resident does not take any fluids during a given shift, write 0 in the shift total column, never leave this column blank.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 37721 Based on observation, review of the clinical record, facility documentation, facility policy and interview, the facility failed to ensure staff verbalized understanding of the protocol for informing personnel and visitors of a resident on Enhanced Barrier Precaution (EBP), specifically as it applies to alerts placed on the resident name plate upon entering the room. The findings include: Review of the EBP resident line list identified 5 rooms had residents on EBP with no visible signage at the entrance to the rooms. A subsequent observation, interview and facility documentation review with RN #1identified she was the assigned Infection Preventionist (IP) for the facility and was responsible for identifying and monitoring residents on transmission-based precautions, including EBP. RN #1 identified orange circular stickers are placed on the name plate outside of each resident room to identify that those residents are on EBP, instead of signage as a matter of maintaining a resident's dignity. RN #1 further identified that although staff and visitors were educated on the use of the stickers as a means of alerting staff and visitors of the precautions, she was unable to provide documentation of the training. Interviews during the standard survey with 3 of 4 licensed staff, LPN #2, LPN #5, LPN #6, and 3 of 4 nurse aide staff, NA #5, NA #6, NA#8 were unable to demonstrate knowledge and verbalize understanding of what the orange sticker placement used on the resident name plates signified. Further, a review of the education for EBP identified 2 of the 4 interviewed nurse aide staff, NA #5 and NA #7 were not included in the documented training. Interview with the DNS on 9/24/24 at 8:30 AM identified staff should be following guidelines for a resident on EBP according to policy. Interview and facility documentation review with Regional Nurse #1 on 9/24/24 at 11:35 AM identified that although information regarding enhanced EBP was on the care card, staff should be verbalizing understanding of the use of orange stickers placed on the resident name plate to alert that a resident was on EBP. A subsequent interview with the DNS on 9/24/24 at 11:35 AM identified she would expect staff to verbalize understanding of the alerts for EBP placed on the resident name plate upon entering the room. Review of the facility policy for Enhanced Barrier Precautions directed that appropriate signage will be visible for a resident on Enhanced Barrier Precautions and that the IP/designee will provide staff, residents or representatives, with education regarding the purpose of enhanced barrier precautions.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 43032 Based on review of facility documentation, facility policy, and interviews, the facility failed to complete performance reviews for nurse aides once every 12 months. Review of facility documentation, including nurse aide personnel files indicated performance reviews were not done for 2023. Interview with the HR Director on 9/23/24 at 10:40 AM identified that she is new to the facility and as a result they were unsure of previous year's performance reviews. Interview with the DNS on 09/24/24 at 10:43AM identified the staff development nurse did the performance reviews last year and she is not working at this time. The DNS indicated she will search her files for information regarding annual reviews. Interview with the Administrator on 9/24/24 at 2:00 PM identified the management team is new to the facility and performance reviews will be addressed going forward. The policy for Performance and Review identified a formal and documented performance review will be done at the end of an employee's introductory period and will endeavor to give reviews at least annually thereafter. The policy further states that the performance plans and reviews provide a systemic and regular opportunity for you to discuss your work expectations, work results and goals with your supervisor. In the process you find out how you are developing and where you stand in relation to what is expected of you. This review process is made in consultation with other supervisory staff in which you have contact and the Administrator. Each employee is required to complete an Employee Self-Evaluation form as an important first step in the performance review process.

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Apple Rehab Rocky Hill	45 Elm Street Rocky Hill, CT 06067

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47457 Based on review of the clinical record, facility documentation, facility policies, and interviews for 5 of 5 residents (Resident #3, 19, 29, 41, and 49) reviewed for immunizations, the facility failed to ensure residents had the opportunity to accept or refuse the 2023-24 Covid-19 vaccine, during the 2023-24 fall/winter virus season. The findings include: Resident #3 was admitted to the facility on [DATE], his/her immunization record identified the last Covid-19 booster offered was on 11/8/22, which he/she refused. Resident #3's clinical record failed to identify that he/she was provided education on the benefits of the Covid-19 booster and that a consent/refusal document had been signed by the resident or resident representative, during the 2023-24 fall/winter virus season. Resident #19 was admitted to the facility on [DATE], his/her immunization record identified the last Covid-19 booster was administered on 7/25/22. Resident #19's clinical record failed to identify that he/she was provided education on the benefits of the Covid-19 booster and that a consent/refusal document had been signed by the resident or resident representative, during the 2023-24 fall/winter virus season. Resident #29 was admitted to the facility on [DATE], his/her immunization record identified the last Covid-19 booster was administered on 1/6/22. Resident #29's clinical record failed to identify that he/she was provided education on the benefits of the Covid-19 booster and that a consent/refusal document had been signed by the resident or resident representative, during the 2023-24 fall/winter virus season. Resident #41 was admitted to the facility on [DATE], his/her immunization record identified the last Covid-19 booster was administered on 12/17/21. Resident #41's clinical record failed to identify that he/she was provided education on the benefits of the Covid-19 booster and that a consent/refusal document had been signed by the resident or resident representative, during the 2023-24 fall/winter virus season. Resident #49 was admitted to the facility on [DATE], his/her immunization record failed to identify historical administration or refusal of either the Covid-19 vaccine or booster. Resident #49's clinical record further failed to identify that Resident #49 was provided education on the benefits of the Covid-19 vaccine or booster and that a consent/refusal document had been signed by the resident or resident representative, during the 2023-24 fall/winter virus season. Interview with the Infection Control Nurse (RN #1) on 9/23/24 at 3:30 PM identified that she was unable to locate signed consent/refusal forms and administration documentation of the 2023-24 Covid-19 vaccine for Residents #3, 19, 29, 41 and 49, for 2023. RN #1 further indicated that she was not the Infection Control Nurse during that time frame and that she was unable to identify why there was no documentation on the residents vaccination status. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075211	A. Building B. Wing	09/24/2024

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the prior Facility Administrator (Administrator from March of 2023 through April of 2024) on 9/23/24 at 3:42 PM identified that a new Covid-19 vaccine came out in the summer of 2023, and the facility had planned on offering a clinic, in place, to provide residents with the appropriate seasonal vaccines, but the FDA had disapproved the vaccine, so they canceled the clinic and canceled the order with the pharmacy. The prior Administrator further identified that the vaccine was not approved until February or March of 2024, but she could not recall if the vaccine was offered to the residents, after the approval; she would have to ask the prior Infection Control Nurse (ICN). Interview with the DNS on 9/23/24 at 4:02 PM identified that she began working at the facility in July of 2023 and that there were conversations that occurred between the prior ICN and the prior Administrator that due to a recall, the 2023-24 Covid-19 vaccine was not being offered. The DNS indicated that she believed the Medical Director was aware that residents were not offered the vaccine, but she could not recall being involved in any conversations with him because the prior Corporate DNS was overseeing the management of the situation. The DNS further identified that the 2023-24 Covid-19 vaccine was not offered to residents or staff during the entire 2023-24 fall/winter virus season and that she was not aware of any approved alternatives that may have been investigated. Interview with the Pharmacy Representative on 9/23/24 at 4:13 PM identified that the facility had not ordered or canceled the 2023-24 Covid-19 vaccine in 2023; the last time Covid-19 vaccines were ordered from the facility was in November of 2022. The Pharmacy Representative further identified that she was unaware of any of the Covid-19 vaccines being recalled or disapproved by the FDA, in 2023, and that the pharmacy had vaccines available that could have been supplied to the facility during the 2023-24 fall/winter virus season but none of them were ordered by the facility. Interview with the Medical Director (MD #1) on 9/23/24 at 5:00 PM identified that he was unaware that the FDA had disapproved the 2023-24 Covid-19 vaccines and that facility residents were not offered or given the vaccine for the duration of the 2023/24 virus season. MD #1 further identified that residents should receive vaccine education, and the vaccine should be recommended; everyone at the facility should receive the vaccine unless the resident or family declined. Although attempted, an interview with the prior Infection Control Nurse was not obtained. The facility's Covid-19 policy encourages everyone to remain up to date with all recommended Covid-19 vaccine doses. The facility's Covid-19 Vaccination policy directs Covid-19 vaccinations will be offered to eligible staff and residents in accordance with the CDC guidance and the adult immunization schedule. The Covid-19 vaccination is a measure to prevent the spread of the Covid-19 virus.